

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: 0041897</p> <p>Facility Name: CARE CENTRE OF URBANA</p> <p>Address: 907 N. LINCOLN AVE. URBANA 61801</p> <p>County: CHAMPAIGN</p> <p>Telephone Number: (847) 674-4700 Fax # (847) 674-4733</p> <p>IDPA ID Number: 36-4082501</p> <p>Date of Initial License for Current Owners: 6/01/96</p> <p>Type of Ownership:</p> <table><tr><td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td>IRS Exemption Code</td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other</td></tr><tr><td></td><td><input checked="" type="checkbox"/> "Sub-S" Corp.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other</td><td></td></tr></table> <p>In the event there are further questions about this report, please contact: Name: DON FIETS Telephone Number: (847) 674-4700 X40</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) BRADLEY ALTER</td><td></td></tr><tr><td></td><td>(Title) SECRETARY</td><td></td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) BOB KAGDA PARTNER</td><td></td></tr><tr><td>(Firm Name &amp; Address) KRKUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712</td><td></td></tr><tr><td>(Telephone) (847) 675-3585</td><td>Fax # (847) 675-5777</td></tr><tr><td colspan="2">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) BRADLEY ALTER			(Title) SECRETARY		Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) BOB KAGDA PARTNER		(Firm Name & Address) KRKUPNICK, BOKOR, KAGDA & BROOKS, LTD. 3750 W. DEVON AVE., LINCOLNWOOD, IL 60712		(Telephone) (847) 675-3585	Fax # (847) 675-5777	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number CARE CENTRE OF URBANA

# 0041897 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 06/01/96 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 12 and days of care provided 1,480

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002  
\* All facilities other than governmental must report on the accrual basis.

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			1,480	1,480	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	18,873	1,663	333	20,869	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,873	1,663	1,813	22,349	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 61.85%

Facility Name & ID Number CARE CENTRE OF URBANA # 0041897 Report Period Beginning: 01/01/2002 Ending: 12/31/2002  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	132,735	3,768	6,064	142,567		142,567		142,567			1
2	Food Purchase		80,164		80,164		80,164	(160)	80,004			2
3	Housekeeping	65,491	21,727		87,218		87,218	297	87,515			3
4	Laundry	42,661	7,219		49,880		49,880		49,880			4
5	Heat and Other Utilities			65,717	65,717		65,717	902	66,619			5
6	Maintenance	29,273	18,304	5,765	53,342		53,342	46	53,388			6
7	Other (specify):*			4,359	4,359		4,359		4,359			7
8	<b>TOTAL General Services</b>	270,160	131,182	81,905	483,247		483,247	1,085	484,332			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			9,105	9,105		9,105		9,105			9
10	Nursing and Medical Records	723,080	43,508	13,677	780,265		780,265	10,978	791,243			10
10a	Therapy	43,719	46	1,700	45,465		45,465		45,465			10a
11	Activities	24,254	1,470		25,724		25,724		25,724			11
12	Social Services	38,602		4,340	42,942		42,942		42,942			12
13	Nurse Aide Training											13
14	Program Transportation			1,275	1,275		1,275		1,275			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	829,655	45,024	30,097	904,776		904,776	10,978	915,754			16
	<b>C. General Administration</b>											
17	Administrative	44,449		23,889	68,338		68,338	7,386	75,724			17
18	Directors Fees											18
19	Professional Services			70,447	70,447		70,447	(41,265)	29,182			19
20	Dues, Fees, Subscriptions & Promotions			20,581	20,581		20,581	(6,415)	14,166			20
21	Clerical & General Office Expenses	66,336	20,498	98,805	185,639		185,639	(34,854)	150,785			21
22	Employee Benefits & Payroll Taxes			208,974	208,974		208,974	14,889	223,863			22
23	Inservice Training & Education			955	955		955		955			23
24	Travel and Seminar			2,840	2,840		2,840	1,480	4,320			24
25	Other Admin. Staff Transportation			2,142	2,142		2,142	2,697	4,839			25
26	Insurance-Prop.Liab.Malpractice			59,031	59,031		59,031	1,097	60,128			26
27	Other (specify):*			2,302	2,302		2,302	(2,302)				27
28	<b>TOTAL General Administration</b>	110,785	20,498	489,966	621,249		621,249	(57,287)	563,962			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,210,600	196,704	601,968	2,009,272		2,009,272	(45,224)	1,964,048			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			20,400	20,400		20,400	(947)	19,453			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,995	87,995		87,995	1	87,996			32
33	Real Estate Taxes			45,850	45,850		45,850		45,850			33
34	Rent-Facility & Grounds			386,167	386,167		386,167	3,526	389,693			34
35	Rent-Equipment & Vehicles			4,955	4,955		4,955	174	5,129			35
36	Other (specify):* <b>STORAGE</b>			830	830		830		830			36
37	<b>TOTAL Ownership</b>			546,197	546,197		546,197	2,754	548,951			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,435	4,038	36,473		36,473		36,473			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		32,435	58,241	90,676		90,676		90,676			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,210,600	229,139	1,206,406	2,646,145		2,646,145	(42,470)	2,603,675			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,390)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(160)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(4,010)	21		18
19	Entertainment		20		19
20	Contributions	(975)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,302)	27		24
25	Fund Raising, Advertising and Promotional	(5,576)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (15,413)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(27,057)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (27,057)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (42,470)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(160)	0	0	0	0	0	0	0	0	0	0	(160)	2
3	Housekeeping	0	0	297	0	0	0	0	0	0	0	0	297	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	902	0	0	0	0	0	0	0	0	902	5
6	Maintenance	0	0	46	0	0	0	0	0	0	0	0	46	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(160)</b>	<b>0</b>	<b>1,245</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,085</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	10,978	0	0	0	0	0	0	0	0	10,978	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>10,978</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,978</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(23,889)	31,275	0	0	0	0	0	0	0	0	7,386	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(44,255)	2,990	0	0	0	0	0	0	0	0	(41,265)	19
20	Fees, Subscriptions & Promotions	(6,551)	0	136	0	0	0	0	0	0	0	0	(6,415)	20
21	Clerical & General Office Expenses	(4,010)	(80,494)	49,650	0	0	0	0	0	0	0	0	(34,854)	21
22	Employee Benefits & Payroll Taxes	0	0	14,889	0	0	0	0	0	0	0	0	14,889	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	1,480	0	0	0	0	0	0	0	0	1,480	24
25	Other Admin. Staff Transportation	0	0	2,697	0	0	0	0	0	0	0	0	2,697	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,097	0	0	0	0	0	0	0	0	1,097	26
27	Other (specify):*	(2,302)	0	0	0	0	0	0	0	0	0	0	(2,302)	27
28	<b>TOTAL General Administration</b>	<b>(12,863)</b>	<b>(148,638)</b>	<b>104,214</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(57,287)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(13,023)</b>	<b>(148,638)</b>	<b>116,437</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(45,224)</b>	<b>29</b>

## Summary B

**12/31/2002**

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEALTH MANAGEMENT	SKOKIE	BOOKKEEPING/MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	17	MANAGEMENT FEES	\$ 23,889	CERTIFIED HEALTH MANAGEMENT		\$	\$ (23,889)	1
2	V	21	BOOKKEEPING	80,494				(80,494)	2
3	V	19	ADMIN. CONSULTING FEES	44,255				(44,255)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 148,638			\$	\$ * (148,638)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 297	\$ 297	15
16	V	5	ELECTRIC & GAS		" " "		902	902	16
17	V	6	MAINTENANCE		" " "		46	46	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		10,978	10,978	18
19	V	17	ADMIN SALARIES		" " "		31,275	31,275	19
20	V	19	PROFESSIONAL FEES		" " "		2,990	2,990	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		136	136	21
22	V	21	OFFICE EXP.		" " "		49,650	49,650	22
23	V	22	EMPLOYEE BENEFITS		" " "		14,889	14,889	23
24	V	24	TRAVEL/SEMINAR		" " "		1,480	1,480	24
25	V	25	TRANSPORTATION		" " "		2,697	2,697	25
26	V	26	INSURANCE		" " "		1,097	1,097	26
27	V	30	DEPRECIATION		" " "		1,443	1,443	27
28	V	32	INTEREST		" " "		1	1	28
29	V	34	OFFICE RENT		" " "		3,526	3,526	29
30	V	35	EQUIPMENT RENTAL		" " "		174	174	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 121,581	\$ * 121,581	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATION		NONE			SALARY	\$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 20,487		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF URBANA# 0041897

Report Period Beginning:

01/01/2002

Ending:

2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

CERTIFIED HEALTH MANAGEMENT

Street Address

3856 OAKTON SUTIE 200

City / State / Zip Code

SKOKIE, IL 60076

Phone Number

(847) 674-4700

Fax Number

(847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	272,818	8	\$ 3,625	\$	22,349	\$ 297	1
2	5	ELECTRIC & GAS	" " "	272,818	8	11,011		22,349	902	2
3	6	MAINTENANCE	" " "	272,818	8	557		22,349	46	3
4	10	NURSING/MEDICAL RECORD	" " "	272,818	8	134,010	134,010	22,349	10,978	4
5	17	ADMIN SALARIES	" " "	272,818	8	381,783	381,783	22,349	31,275	5
6	19	PROFESSIONAL FEES	" " "	272,818	8	36,495		22,349	2,990	6
7	20	FEE, SUBSCRIPTIONS	" " "	272,818	8	1,662		22,349	136	7
8	21	OFFICE EXP.	" " "	272,818	8	606,084	496,771	22,349	49,650	8
9	22	EMPLOYEE BENEFITS	" " "	272,818	8	181,747		22,349	14,889	9
10	24	TRAVEL/SEMINAR	" " "	272,818	8	18,072		22,349	1,480	10
11	25	TRANSPORTATION	" " "	272,818	8	32,928		22,349	2,697	11
12	26	INSURANCE	" " "	272,818	8	13,389		22,349	1,097	12
13	30	DEPRECIATION	" " "	272,818	8	17,618		22,349	1,443	13
14	32	INTEREST	" " "	272,818	8	9		22,349	1	14
15	34	OFFICE RENT	" " "	272,818	8	43,046		22,349	3,526	15
16	35	EQUIPMENT RENTAL	" " "	272,818	8	2,124		22,349	174	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,484,160	\$ 1,012,564		\$ 121,581	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5	AICC			INS. FINANCING								1,123	5
	Working Capital												
6	BANK FINANCIAL		X	WORKING CAPITAL					75,927			8,714	6
7	SHAREHOLDER LOANS	X		WORKING CAPITAL					1,271,000			78,158	7
8	RELATED PARTY		X									1	8
9	TOTAL Facility Related						\$		\$ 1,346,927			\$ 87,996	9
	B. Non-Facility Related*												
10	IRS, IDR, ETC		X	LATE FEES									10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$ 1,346,927			\$ 87,996	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ \_\_\_\_\_      Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2001 report.	\$	44,309	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	44,633	2
3. Under or (over) accrual (line 2 minus line 1).	\$	324	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	45,526	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	45,850	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	41,655	8
	1998	42,808	9
	1999	42,830	10
	2000	43,440	11
	2001	44,633	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.			
		FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF URBANA COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041897

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE ( 847 ) 675-3585 FAX #: ( 847 ) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	91-21-07-282-021	NURSING HOME	\$ 44,633.00	\$ 44,633.00
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 44,633.00	\$ 44,633.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet: 32,000

B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity?

☐ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☒ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILES,WALLPAPER,PAINTING,HANDRAILS			1997	30,742	788	39	788	0	4,431	9
10	REPAIR PARKING LOT			1997	5,347	356	15	356	0	1,962	10
11	ROOF EXHAUSTER, VENTILATION			1997	4,926	126	39	126	0	674	11
12	CEILING,DUCTWORK,DOOR			1998	10,864	279	39	279	(0)	1,277	12
13	TILE/INSTALLATION			1998	4,650	119	39	119	0	531	13
14	HVAC UNIT			1998	6,162	158	39	158		701	14
15	NURSES STATION REPAIR			1998	12,552	322	39	322	(0)	1,722	15
16	300 WING RENOVATION			1998	7,859	202	39	202	(0)	867	16
17	FIRE PROTECTION SYSTEM/DAMPERS			1999	37,334	957	39	957	0	3,014	17
18	LANDSCAPING/SIDEWALK			1999	17,035	437	39	437	(0)	1,376	18
19	WALL REPAIR/TILE/HANDRAIS/BUMPERS			2000	8,740	248	27.5	318	70	792	19
20	BASEBOARD HEAT			2000	2,306	123	27.5	84	(39)	263	20
21	NEW WATER SERVICE/WATER HEATER			2000	10,597	415	27.5	385	(30)	1,074	21
22	FIRE ALARM WORK			2000	9,647	351	27.5	351	(0)	952	22
23	ROOF REPAIR			2001	11,820	430	27.5	430	(0)	699	23
24	ROOF REPAIR			2001	3,056	111	27.5	111	0	143	24
25	WALL REPAIR AND TILE			2001	2,301	84	27.5	84	(0)	94	25
26	AIR CONDITIONERS			2002	11,670	149	27.5	212	63	212	26
27	DOORS-ALZ UNIT			2002	5,922	76	27.5	108	32	108	27
28	ALARMS SYSTEM			2002	1,982	25	27.5	36	11	36	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.
 \*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 205,512	\$ 5,756		\$ 5,863	\$ 107	\$ 20,928	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$121,478	\$14,644	\$12,148	\$(2,496)	10 YRS	\$51,344	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	RELATED PARTY		1,443	1,443				74
75	TOTALS	\$121,478	\$16,087	\$13,591	\$(2,496)		\$51,344	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$326,990	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$21,843	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$19,453	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(2,390)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$72,271	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: CARE CENTER OF URBANA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

☒ YES

☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		99	6/1/96	\$386,167			3
4	Additions							4
5								5
6								6
7	TOTAL		99		\$386,167			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease.
9. Option to Buy: 

☒ YES

☐ NO

 Terms: PURCH AFTER 6/1/16 \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO
16. Rental Amount for movable equipment: \$4,955 Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning6/1/96

Ending5/31/21

11. Rent to be paid in future years under the current rental agreement:
- Fiscal Year Ending

Annual Rent

12.12/31/2003\$393,721

13.12/31/2004\$409,256

14.12/31/2005\$411,788

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist						39-3	hrs	\$	
2	Licensed Speech and Language Development Therapist	39-3	hrs			425			425	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,512			2,512	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				22,063		22,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LABORATORY	39-2 39-2					9,117 1,255		9,117 1,255	13
14	TOTAL			\$		\$ 4,038	\$ 32,435		\$ 36,473	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 36,000 )	268,815		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,308		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	39,581		8
9	Other(specify): REAL ESTATE ESCROW	35,731		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 361,435	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	193,842		15
16	Equipment, at Historical Cost	133,147		16
17	Accumulated Depreciation (book methods)	(110,638)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	297,000		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 513,351	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 874,786	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 88,298	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,000		28
29	Short-Term Notes Payable	1,882,809		29
30	Accrued Salaries Payable	49,694		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,313		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,526		32
33	Accrued Interest Payable	269,078		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,348,718	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,348,718	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,473,932)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 874,786	\$	48

\*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,273,946)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,273,946)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(199,986)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (199,986)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,473,932)	24 *

\* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	1
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,411,896	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,411,896	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,795	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 26,795	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	3,847	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,847	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DISCOUNTS</b>	1,656	28
28a	<b>VENDING COMMISSIONS</b>	1,965	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,621	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,446,159	30

	Expenses	Amount	2
	<b>A. Operating Expenses</b>		
31	General Services	483,247	31
32	Health Care	904,776	32
33	General Administration	621,249	33
	<b>B. Capital Expense</b>		
34	Ownership	546,197	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	36,473	35
36	Provider Participation Fee	54,203	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,646,145	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(199,986)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (199,986)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

TAX RETURN CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,969	2,025	\$ 44,886	\$ 22.17	1
2	Assistant Director of Nursing	1,984	2,080	33,466	16.09	2
3	Registered Nurses	6,028	6,244	117,470	18.81	3
4	Licensed Practical Nurses	8,988	9,478	128,087	13.51	4
5	Nurse Aides & Orderlies	32,547	32,678	363,840	11.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,972	3,258	43,719	13.42	8
9	Activity Director	1,310	1,352	14,035	10.38	9
10	Activity Assistants	1,071	1,284	10,219	7.96	10
11	Social Service Workers	2,678	2,814	38,602	13.72	11
12	Dietician					12
13	Food Service Supervisor	2,024	2,080	35,289	16.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,175	7,357	61,307	8.33	15
16	Dishwashers	4,925	5,144	36,139	7.03	16
17	Maintenance Workers	1,918	2,074	29,273	14.11	17
18	Housekeepers	7,317	7,319	65,491	8.95	18
19	Laundry	5,661	5,707	42,661	7.48	19
20	Administrator	2,040	2,080	44,449	21.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,982	2,198	31,107	14.15	23
24	Clerical	4,056	4,200	35,229	8.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,714	1,842	16,741	9.09	31
32	Other Health Care(specify)					32
33	Other(specify) <u>care plan</u>	1,719	1,775	18,590	10.47	33
34	TOTAL (lines 1 - 33)	100,078	102,989	\$ 1,210,600 *	\$ 11.75	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	130	\$ 5,474	1-3	35
36	Medical Director	monthly	9,105	9-3	36
37	Medical Records Consultant	140	5,584	10-3	37
38	Nurse Consultant	35	1,731	10-3	38
39	Pharmacist Consultant	monthly	825	10-3	39
40	Physical Therapy Consultant	16	725	10a-3	40
41	Occupational Therapy Consultant	16	750	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	5	225	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	monthly	4,340	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	342	\$ 28,759		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides	80	1,834	10-3	52
53	TOTAL (lines 50 - 52)	80	\$ 1,834		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
MARK BERG	ADMIN	0	\$ 17,209	Workers' Compensation Insurance		\$ 32,238	IDPH License Fee	\$ 200
LADONNA NCNEW	ADMIN	0	27,240	Unemployment Compensation Insurance		30,235	Advertising: Employee Recruitment	6,559
				FICA Taxes		91,653	Health Care Worker Background Check	0
				Employee Health Insurance		47,890	(Indicate # of checks performed )	
				Employee Meals		#REF!	MARKETING/ADV/PROMO	5,576
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC	975
				EMPLOYEE BENEFITS - OTHER		4,609	LICENSES & PERMITS	2,119
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS	5,152
				PENSION/PROFIT SHARING PLANS		2,349	RELATED PARTY	136
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC	(975)
(List each licensed administrator separately.)			\$ 44,449	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense (	0 )
B. Administrative - Other				RELATED PARTY		14,889	Non-allowable advertising	(5,576)
Description			Amount	INSURANCE - EXECUTIVE LIFE VI 21		0	Yellow page advertising (	0 )
MANAGEMENT FEES			\$ 23,889					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 23,889	TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
(Attach a copy of any management service agreement)						\$ #REF!		\$ 14,166
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
								2,840
							Seminar Expense	
							RELATED PARTY	1,480
SEE SCHEDULE ATTACHED			70,447				Entertainment Expense (	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 70,447			\$	TOTAL	\$ 4,320

\* Attach copy of IMRF notifications

\*\*See instructions.

**(See instructions.)**

[illegible]

Facility Name &amp; ID Number CARE CENTRE OF URBANA

# 0041897

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. IL HEALTH CARE ASSOC\$6,149
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? YES  
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 54,203  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ #REF! Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 5%  
d. Have vehicle usage logs been maintained? NO  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES  
**g. Does the facility transport residents to and from day training? NO**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	5,474
	REPAIRS & MAINTENANCE	590
		0
		6,064
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	9,229
	ELECTRICITY	45,641
	WATER	10,354
	CABLE TV - LOBBY	493
		0
		65,717
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	(125)
	PAINTING & DECORATING	296
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	881
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	1,020
	FIRE SERVICE	3,693
		0
		0
		0
		5,765
7	<b>OTHER</b>	
	SCAVENGER	4,359
	SECURITY SERVICE	0
		4,359
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	9,105
		9,105

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	1,834
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	3,703
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	5,584
	PHARMACY CONSULTANT XVIII B 39-2	825
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	1,731
		0
		0
		13,677
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	
	OCCUPATIONAL THERAPY SERVICES	
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	725
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	750
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	225
		1,700
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,340
		0
		4,340
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

## V.COST CENTER EXPENSES

## PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	1,275
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	23,889
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,042
	ADMINISTRATIVE CONSULTANTS XIX C	44,255
	PROFESSIONAL FEES XIX C	21,150
		0
		70,447
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	5,576
	EMPLOYEE WANT ADS XIX F	6,559
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	5,152
	LICENSES & PERMITS XIX F	2,319
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	975
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	619
	EQUIPMENT REPAIR & MAINTENANCE	841
	OUTSIDE CLERICAL SERVICES	80,494
	PENALTIES / OVERDRAFT CHARGES VI 18	4,010
	OFFICE EXPENSES	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,841
		98,805

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	91,653
	UNEMPLOYMENT COMPENSATION XIX D	30,235
	WORKERS COMPENSATION INSURANC XIX D	32,238
	HOSPITALIZATION INSURANCE XIX D	47,890
	EMPLOYEE BENEFITS - OTHER XIX D	4,609
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	2,349
	CHICAGO HEAD TAX XIX D	0
		208,974
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	955
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	
	TRAVEL XIX G	2,840
		0
		0
		2,840
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	2,142
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	59,031
27	<b>OTHER</b>	
	BAD DEBTS VI 24	2,302
		0
		2,302

GRAND TOTAL COLUMN 3 OTHER

601,968